



Board of Optometry
 2420 Del Paso Road, Suite, 255
 Sacramento, CA 95834
 Tel: (916) 575-7170
www.optometry.ca.gov



REPORT OF SETTLEMENT, JUDGEMENT OR ARBITRATION AWARD

Required pursuant to Business & Professions Code Sections 801, 801.1, 802 and 803.2

INSURER/PUBLIC ENTITY

1. Name _____	2. Telephone _____
3. Address _____	

OPTOMETRIST/PROVIDER

4. Name _____	5. License Number _____
6. Address(es) _____	
7. Policy Number _____	
8. Counsel's Name _____	9. Counsel's Telephone _____
10. Address _____	

NOTE: On reverse, enter full name(s) of other optometrists or eye care providers who were claimed or alleged to have acted improperly, whether or not such persons were named as defendants, or whether or not any recovery or judgement was against such persons. If any monies were paid on behalf of those listed, please indicate the amount.

PLAINTIFF/CLAIMANT

11. Name _____	
12. Address(es) _____	
Business _____	
Residence _____	
13. Incident Date _____	14. Patient Name _____
15. Patient Date of Birth _____	16. Counsel's Name _____
17. Counsel's Telephone Number _____	
18. Address _____	

NOTE: Enter on reverse, a description or summary of the facts upon which each claim, charge or judgement rested including date of occurrence. Explain specifically whether death or personal injury occurred as a result of the negligence, error or omission in practice, or rendering of unauthorized professional services by the insured. Attach additional sheets as necessary. Photocopies of any pertinent documents which contain this information may be attached instead.

19. Case Resulted in: (Check one) <input type="radio"/> Settlement <input type="radio"/> Judgement <input type="radio"/> Arbitration Award		20. Date Resolved: _____	
21. Total Amount of Award: _____		22. Total Paid on Behalf of Optometrist: _____	
23. Name and Location of Court/Arbitrator: _____	24. Filing Date: _____	25. Docket Number: _____	

I certify under penalty of perjury under the laws of the State of California that to the best of my knowledge the information provided within this report and any attachments is true and correct.

 Signature of Responsible Agent or Insurer

 Name and Title (Printed or Typed)

 Date